

## PRE-DEPLOYMENT Health Assessment

Authority: 10 U.S.C. 136 Chapter 55. 1074f, 3013, 5013, 8013 and E.O. 9397

Principal Purpose: To assess your state of health before possible deployment outside the United States in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care to you.

Routine Use: To other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

Disclosure: (Military personel and DoD civilian Employees Only) Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

**INSTRUCTIONS:** Please read each question completely and carefully before marking your selections. Provide a response for each question. If you do not understand a question, ask the administrator.

Demographics									
Last Name				Today	y's Date	(dd/mm/yyyy)			
						/			
First Name			MI	Socia	l Secur	ity Number			
						_			
Deploying Unit				DOB (	(dd/mm	/уууу)			
						/ /			
Gender	Service Branch	Component				Pay Grade			
O Male	O Air Force	O Active Duty				O E1 O O1 O W1 O E2 O O2 O W2			
O Female	O Army	O National Guard				O E3 O O3 O W3			
	O Coast Guard	O Reserves				O E4 O O4 O W4			
	O Marine Corps	O Civilian Government E	Employe	е		O E6 O O6 O Other			
	O Navy					O E7 O O7 O E8 O O8			
	O Other					O E9 O O9 O O O O O O O O O O O O O O O			
Location of (	Inoration					0 0 10			
Location of C									
O Europe	<ul><li>Australia</li></ul>								
O SW Asia	O Africa								
O SE Asia	O Central America	r							
O Asia (Other)	Asia (Other) O Unknown			Administrator Use Only					
O South Ameri	ca		Indic	ate the	status	of each of the following:			
Deployment Location (IF KNOWN) (CITY, TOWN, or BASE):			Yes	No	N/A				
			0	0	O V	fledical threat briefing completed			
List country (IF KNOWN):			0	0	0 1	Medical information sheet distributed			
List Country (II	RIVOTVIVJ.		0	0	0 5	Serum for HIV drawn within 12 months			
			0	0	0 1	mmunizations current			
Name of Opera	ition:		0	0	O F	PPD screening within 24 months			



## PLEASE FILL IN SOCIAL SECURITY #

|--|

Health Assessment  1. Would you say your health in general is:		O Excellent	O Very Good	O Good	○ Fair	O Poor			
Do you have any medical or dental problems'	?	O Excomonic	O ( o )	0 2222		O N			
<ol> <li>Are you currently on a profile, or light duty, or</li> </ol>		medical board?			O Yes	O No			
	, , ,		○ Don	't Know	○ Yes ○ Yes	O No O No			
4. Are you pregnant? (FEMALES ONLY)	stice esodication or high	control nillo?	0 5011	O N/A	O Yes	O No			
<ol><li>Do you have a 90-day supply of your prescrip</li></ol>									
6. Do you have two pairs of prescription glasses	s (if worn) and any othe	r personal medi	ical equipment?	O N/A	O Yes	O No			
7. During the past year, have you sought couns	eling or care for your m	ental health?			O Yes	O No			
8. Do you currently have any questions or conce	erns about your health?				○ Yes	O No			
Please list your concerns:									
	Service Member Signa	ature							
I certify that responses on this form are true.	Ţ.								
t certify that respondes on the form are true.									
Pre-Deployment Health Provider Review (For H	lealth Provider Use Only	/)							
After interview/exam of patient, the following p noted for patients with multiple prob	problems were noted and plems. Further documer	d categorized b ntation of proble	y Review of Syst em to be placed	ems. Mor in medical	e than one records.	may be			
REFERRAL INDICATED	O GI								
○ None	O GU								
O Cardiac	O GYN								
O Combat / Operational Stress Reaction	○ Mental Health								
O Dental	○ Neurologic								
O Dermatologic	○ Orthopedic								
O ENT	O Pregnancy								
O Eye	<ul><li>Pulmonary</li></ul>								
O Family Problems	•								
O Fatigue, Malaise, Multisystem complaint	O Other								
	○ Deployable	e	O Not Deplo	yable					
FINAL MEDICAL DISPOSITION:  Comments: (If not deployable, explain)	○ Deployable	•	O Not Deplo	yable					
I certify that this review process has been comp. Provider's signature and stamp:	leted.	Date	(dd/mm/yyyy)						
				/					

End of Health Review

33023